North Carolina – Treatment Outcomes and Program Performance System (NC-TOPPS)

Advisory Committee

January 25, 2007 Meeting Minutes

Attendees

Member/Representatives:

Kent Earnhardt	Wake County Consumer and Family Advisory Committee (CFAC)
Sharon Garrett	Vision Consulting
Robin Gravely	PBH
Dan Herr	Orange-Person-Chatham (OPC) CFAC
Malika Roman Isler	Insight Human Services (Partnership for a Drug Free NC)
Jeannie King	Mentor
Connie Mele	Mecklenburg County Area MH, DD, SA Authority
Ann Paquette	Triumph
David Peterson	Wake County Human Services
Andy Smitley	Sandhills Center for MH, DD & SAS
Janice Stroud	The Durham Center
Diocles Wells	Southeastern Center

Guests:

Byron Brooks	SE Regional AHEC
Margaret Clayton	Five County Mental Health Authority
Richard Edwards	Easter Seals UCP NC
Petra Halker	The Guilford Center
Janis Kupersmidt	Innovation Research and Training, Inc.
Sara McEwen	Governor's Institute on Alcohol and Substance Abuse
Nikki Migas	The Commission on Accreditation of Rehabilitation Facilities (CARF)
Pamela Moye	The Guilford Center CFAC
Alision Parker	Innovation Research and Training, Inc
Sabrina Russell	The Guilford Center
Jay Taylor	Pathways

Staff:

Jim Jarrard	Accountability Team Leader, North Carolina Division of Mental Health Developmental Disabilities and Substance Abuse Services (NC DMHDDSAS)
Nidu Menon	Quality Management Team, NC DMHDDSAS
Chris Phillips	Chief, Advocacy and Customer Services Section, NC DMHDDSAS
Shealy Thompson	Quality Management Team Leader, NC DMHDDSAS
Karen Eller	North Carolina State University's Center for Urban Affairs and Community Services (NCSU CUACS)
Jaclyn Johnson	NCSU CUACS
Kathryn Long	NCSU CUACS
Stuart Severns	NCSU CUACS

Mindy McNeely	NCSU CUACS
Marge Cawley	National Development and Research Institutes, Inc. (NDRI)
	NDRI
Glenda Clare	NDRI
Gail Craddock	NDRI
Deena Medley-Murphy	NDRI

Meeting Convened

- Cawley convened the meeting at 10:00 a.m. by announcing the expansion of the Advisory Committee to include more providers and consumers. Cawley introduced the new provider members to the Committee: Triumph, represented by Ann Paquette, and Mentor, represented by Jeannie King. Cawley introduced the new representatives for three of our standing member organizations: Diocles Wells, SE Center; Robin Gravely, PBH; and Malika Roman Isler, Partnership for a Drug Free NC. Cawley also shared that Pamela Moye, a member of The Guilford Center CFAC, is attending today's meeting to see if this is a committee she would like to join. Cawley ended with the information that Janice Stroud, a long standing member from The Durham Center, will be retiring in the next couple of months. Today's meeting will be Ms. Stroud's last meeting as a formal member.

October 26, 2006 Meeting Minutes Approved

CFAC Legislation

- Chris Phillips, Chief, Advocacy and Customer Services Section for the Division, walked the Committee through the "Implications for Local Consumer and Family Advisory Committees" from the latest Consumer and Family Advisory Committee (CFAC) legislation - S.L. 2006-142 Section 5, House Bill 2077.
- He shared his PowerPoint presentation and another handout that highlights a "CFAC & LME Action Plan." Contact Cawley@ndri-nc.org for copies of these handouts.
- Article 4, Chapter 122 C-170 defines the roles and responsibilities of local CFACS. Chapter 122 C-179 states that area authorities and county programs shall establish committees comprised of consumers and family members to be known as Consumer and Family Advisory Committees (CFACs). A local CFAC shall be a self-governing and self-directed organization that **advises** the area authority or county program in its catchment area on the *planning and management* of local public mental health, developmental disabilities and substance services (mhddsas). Each CFAC shall adopt bylaws governing: selection and appointment of its members; terms of service; number of members; and other procedural matters. When requested by either the local CFAC or the Governing Board of the Area Authority or County Program, the CFAC and the Governing Board shall execute an agreement that identifies: the roles and responsibilities of each party; channels of communication between the parties; and a process for resolving disputes between parties.
- Subsection B defines local CFAC member composition and length of terms. Each of the disability groups will be *equally* represented and shall reflect as *closely as possible* the racial and ethnic composition of the catchment area. Membership will be

comprised exclusively of adult consumers and family members of consumers of mental health, developmental disabilities and substance abuse services. Members will serve three year terms and no member may serve more than *two consecutive terms*. Phillips also included example matrices to aid in establishing appropriate disability representation in using staggered terms.

- Subsection C specifies local CFAC duties:
  - Review, comment on, and monitor the implementation of the local business plan
  - Identify service gaps and underserved populations
  - Make recommendations regarding the service array and monitor the development of additional services
  - Review and comment on the area authority or county program budget
  - Participate in all quality improvement measures and performance indicators
  - Submit to the State CFAC findings and recommendations of ways to improve the delivery of mhddsas services.
- Subsection C also requires the area authority or county program to provide sufficient staff to assist the local CFAC in implementing its duties. This required assistance includes: providing data for the identification of service gaps and underserved populations; training to review and comment on business plans and budgets; procedures to allow participation in quality monitoring; and technical advice on rules of procedure and applicable laws.
- Phillips also reviewed the legislation defining the State CFAC. Chapter 122 C 171 establishes the committee, defines responsibilities and describes membership composition. The State CFAC shall be a self-governing and self-directed organization that advises the Department of Health and Human Services (DHHS) and the General Assembly on the planning and management of the State's public mhddsas system. The State CFAC will be comprised of 21 members that will be exclusively adult consumers and family members of consumers of MHDDSAS services. Similar to the local CFACs terms will be three years long with no more than two consecutive terms. Vacancies will be filled by the following appointing authorities.
- The appointing authorities consist of the Secretary of the DHHS, the President Pro Tempore of the Senate, the Speaker of the House of Representatives, the NC Council of Community Programs and the NC Association of County Commissioners.
  - The Secretary appoints nine members who reflect each of the disability groups whose terms shall be staggered such that three appointees' terms will expire each year.
  - The other four appointing authorities shall each appoint three members each of whom shall come from the three State regions for institutional services (Eastern, Central and Western Regions). These appointees' terms shall be staggered so that the term of one appointee expires every year.
  - The following table shows current State CFAC membership:

Western Region	Central Region	Eastern Region
David Taylor DD Consumer, House, 1 Year	Carl Britton-Watkins SA Con/Fam, House, 3 Years	Kathy Daughtry MH Con/Fam, House, 2 Years
Bill Cook SA Consumer, Senate, 1 Year	Colleen Vaughan MH Consumer, Senate, 3 Years	Zachariah Commander DD Consumer, Senate, 2 Years
Andrea Stevens DD Family Member, NCCCP, 1 Year	Amelia Thorpe MH Consumer, NCCCP, 2 Years	Terry Burgess MH Consumer, NCCCP, 3 Years
Fred McClure MH Consumer, NCACC, 3 Years	David Smitherman MH Family Member, NCACC, 2Years	Dorothy O'Neal SA Consumer, NCACC, 1 Year
Ron Kendrick DD Family Member, Secretary, 3 Years	Carol DeBerry SA Consumer, Secretary, 1 Year	Tisha O'Neal-Gamboa MH Family Member, Secretary, 2 Years
Marian Spencer SA Family Member, Secretary, 2 Years	Cynthia Vester Booth SA Consumer, Secretary, 2 Years	Pat Coleman SA Consumer, Secretary, 3 Years
Wilda Brown DD Family Member, Secretary, 1 Year	Tammy Fletcher DD Fam. Member, Secretary, 3 Years	Judith Dempsey CO Family Member, Secretary, 1 Year

- State CFAC required tasks include: 1) reviewing, commenting on and monitoring implementation of the State Plan for the Division of MHDDSAS; 2) identifying service gaps and underserved populations; 3) making recommendations regarding the service array and monitoring the development of additional services; 4) reviewing and commenting on the State budget for mental health, developmental disabilities and substance abuse services; 5) participating in all quality improvement measures and performance indicators; 6) receiving the findings and recommendations of local CFACs determining ways to improve the delivery of mhddsas; and 7) providing technical assistance to local CFACs in implementing their duties. The Secretary of the DHHS is required to provide sufficient staff to assist the State CFAC in implementing its required tasks.
- The CFAC and LME Action Plan handout provides a tool for local CFACs and their LMEs to frame the six local CFAC task obligations and provide columns for developing strategies to meet obligations and another column for results.
- Currently the local CFACs are in a formative stage. To follow their evolution Phillips' Section produces a quarterly summary report on the various CFACs describing and explaining what they are doing, what problems they are facing and how they are developing. Based on his section's work so far, he is observing a lack of a clear process in how to involve the local CFACs in LME Quality Management. He advocates that each CFAC and its LME work together to develop policy and processes to clearly ensure CFAC involvement in LME Quality Management.
- When asked he answered that on average local CFACs meet once a month for about three hours.

CFAC Members Perspectives on Use of Outcomes

- Dan Herr, OPC CFAC and NC-TOPPS Advisory Committee member, presented on "Orange-Person-Chatham's (OPC) and OPC CFAC's Experience with NC-TOPPS." (For a copy of his PowerPoint handout, contact Cawley@ndri-nc.org.)
- Herr began with a discussion on OPC's history with NC-TOPPS. OPC started using NC-TOPPS in 2000 with perinatal/maternal service providers. Then in 2004 OPC began to implement NC-TOPPS for the substance abuse Adult High Management target population. After implementation of the online NC-TOPPS and following OPC divestiture of nearly all of its services, OPC staff provided training and one on one contact with providers to improve NC-TOPPS compliance. Results of these compliance efforts have produced the following results:
  - An overall decrease in Updates due
  - Approximately 65% of existing providers are implementing NC-TOPPS, although they are not yet reporting on 100% of consumers
  - Approximately 59% of existing providers have been trained in the use of NC-TOPPS
- OPC developed strategies for NC-TOPPS implementation compliance improvement. These include:
  - Providing NC-TOPPS training on a quarterly basis. In addition, special outreach efforts will be made to providers who have yet to use NC-TOPPS or have not attended a training
  - Implementing a new admissions tracking system through the use of the Person Centered Plan (PCP) Consumer Admission
  - Increasing participation and compliance by effective use of available reports
  - Working with providers to improve their results by incorporating available reports into our provider performance/outcomes evaluations.
- OPC has received feedback from providers delineating challenges to complete NC-TOPPS.
  - Some providers complain that the tool is too lengthy and burdensome. Some complain about the number of State requirements, particularly in a system that they see frequently changes. In midst of all the things providers are told they "must" do, some providers give NC-TOPPS a lower priority.
  - Not all providers are required to use NC-TOPPS, such as those serving the DD population and providers who are not the "clinical home." There is a concern that NC-TOPPS Interviews are not being done on consumers that should have an NC-TOPPS completed.
  - The turnover in providers makes it difficult to maintain an accurate, up-to-date list of providers who are responsible for completing NC-TOPPS Interviews.
  - Another challenge is with what OPC staff call system disconnects. For example, OPC only knows that a provider has admitted a new client when they register that client with the LME. Problems have arisen with providers who are directly enrolled with DMA. A few providers fail to register their Medicaid clients now that they can directly enroll with DMA.
- The OPC CFAC engagement with NC-TOPPS began in 2005 when NDRI and CUACS staff provided an overview of the electronic NC-TOPPS prototype to its members. OPC CFAC members positively reviewed NC-TOPPS and were excited

about being able to use its data. However, to date OPC's NC-TOPPS database lacks enough data for the CFAC to use this information effectively.

- OPC CFAC identified potential uses of the NC-TOPPS tool:
  - To monitor and assess current providers within the OPC catchment area, versus state-wide best practices, developing a relative assessment within the catchment area is preferred. The CFAC would really like access to data on all providers to see what is working well for consumers.
  - Develop a map alignment of local provider services and outcomes with OPC identified infrastructure needs and gaps in appropriate services
  - Screen potential providers for safe and appropriate services/outcomes
  - Develop a best practices blend of service options for specific consumer needs
  - Explore trade-offs between local and non-local service options.

  Attendees discussed how some LMEs are looking at wanting to use NC-TOPPS data in provider indicator reports. Staff attendees raised cautions that included needing enough numbers for each provider to be included in a report plus awareness of case mix issues. Other LMEs want to look at what factors impact outcomes by using reports that compare providers. The discussion ended with support for developing a collaborative process that shows how to begin using NC-TOPPS data.
- Herr ended his presentation with requests of potential modifications to NC-TOPPS. OPC LME staff request the following:
  - Modify the NC-TOPPS Update notices to be for a month period rather than a two-week period. OPC has provided reminders and feels that providing one reminder per month would be better than doing two or more per month.
  - Create a report that allows LMEs to compare outcomes of similar providers (e.g., all psych-social rehab providers, all community support providers) within the OPC catchment area. OPC and its CFAC want to be able to compare outcomes of its own providers.
  - Develop a timely custom report capability that enables LMEs to develop queries, run reports and download relevant data as needed. The goal is to eliminate having to ask for reports as special requests to the web administrators.
  - Finalize the online NC-TOPPS data collection system for the DD population as soon as possible, so that providers need not use more than one tool for outcomes measurement.

  OPC CFAC requests the following:
  - Transparent access to customized reports would facilitate OPC CFAC's use of NC-TOPPS.
  - A common framework for CFAC reports would enhance the value and effectiveness of inter-CFAC, CFAC-Provider and CFAC-LME dialog.
  - At some point, CFAC members may benefit from a tool that allowed one to examine aggregates of specific consumer diagnostic-outcome data. OPC CFAC members would be interested in discussing how best to identify significant continuous improvement opportunities in the PCP process. Currently, treatment plans do not seem to tie to outcomes.

The Commission on Accreditation of Rehabilitation Facilities (CARF) Informational Presentation

- Nikki Migas, CARF representative, introduced herself and CARF to the Advisory group and outlined her presentation. Before lunch she provided general information on CARF accreditation and then after lunch she led the group through an outcomes management system exercise.
- Migas shared that she had brought two copies of CARF's Introduction to Behavioral Health Outcomes, Outcomes Management Systems: A Guide to Development and Use. These copies were passed around the room for attendees' perusal. Cawley noted that she will keep these documents and if anyone wants to see or have a copy of them they should contact her. Migas also pointed out that Cawley had brought a 2007 CARF Manual for members to review if they would like. If attendees would like to order any CARF documents they can go to the CARF website, www.carf.org, to do so.
- Migas began her PowerPoint presentation, "CARF 2006 Behavioral Health/OTP/Child & Youth Services Standards" by noting that CARF approaches accreditation standards from two levels: a macro, business perspective, and micro, assessment and individual planning perspective. She noted CARF assumes that service organizations are run like any business. CARF's philosophy of developing quality management standards is similar to that of ISO 9000. (For a copy of her PowerPoint handout, contact Cawley@ndri-nc.org.)
- CARF has ten criteria that are assessed under Business Practices: input from stakeholders; accessibility; information management and performance improvement; rights of persons served; health and safety; human resources; leadership; legal requirements; financial planning and management; and governance.
- CARF-accredited organizations continually focus on the expectations of the persons served and other stakeholders. CARF surveyors assess if the organization is soliciting, collecting, analyzing and using input from all stakeholders to provide the best service possible. She provided examples of stakeholders: persons served; family members; and organization personnel. Ways to assess if organization leadership uses stakeholder input is to look at the organization's program planning, performance improvement process, strategic planning, organization advocacy, financial planning, and resource planning. Migas observed based on the prior CFAC presentations that surveyors in NC would know to contact CFAC members as part of the stakeholder community. A key quality of CARF-accredited organizations are that they share and provide consumers and other interested stakeholders with ongoing information about the organization's actual performance and its ability to achieve optimal outcomes for the persons they serve through its programs and services.
- Data collected should provide information on the needs of persons served and other stakeholders and of the business needs of the organization. A key question of service providing organizations is what kind of difference do we make in the lives of the people we serve. The data should provide for comparative analysis to benchmarks and/or analysis overtime. The data collected should be reliable, valid, complete and accurate.
- A CARF-accredited organization will set performance goals and measure performance indicators that are developed based on its performance goals. For

service delivery improvement the established data collection system should include information on the characteristics of the persons served. This information should be collected at the beginning of services to provide a baseline, then at appropriate in service intervals, at the end of services and then at some point(s) after services have ended, aftercare. When the information for aftercare is gathered should be based upon what is appropriate for the type of consumer. This determination can be based on what research shows is appropriate. In addition, CARF does not necessarily require a certain level of aftercare response; it does, however, look at the organization's efforts to gather this data and to reach consumers.

- CARF looks for measures of performance indicators in the following areas: effectiveness of services (Did services make a difference in the consumer's life?); efficiency of services (What did it cost in time and money? How does this compare to other modalities?); Service access (Were consumers able to get to and receive services?); and satisfaction assessment of consumers and other stakeholders (Do consumers find the services helpful?).
- The CARF-accredited organization's service delivery data collection system will address for each indicator: to whom the indicator applies; how the data will be collected; and a performance goal. Performance goals will be based on one or more of the following: industry benchmark; organization's history; an established target set by the organization or stakeholder(s); and assessment of extenuating/influencing factors.
- Performance analysis should be conducted at least annually for business functions and service delivery. The analysis identifies areas for improvement that results in action plan development that not only specifies actions to take but outlines how the action will improve performance. Performance analysis is used to: 1) review implementation of mission and core values; 2) improve the quality of programs and services; and 3) facilitates organizational decision-making and strategic planning. Finally, the performance analysis information is shared in a way that is useful to consumers, organization staff and other stakeholders.
- In the next part of her presentation, Migas highlighted two general program standards: screening and access to services and the individual plan. Within each she provided examples of standard intent and how organizations would show they are meeting the standard.
- For screening and access to services the intent states that the process "is designed to maximize opportunities for the persons served to gain access to the organization's programs and services." It emphasizes that persons served are actively involved and significantly so in the assessment process. Assessments need to be conducted in a timely manner with recognition of consumers' strengths, needs, abilities and preferences. Assessment data may be gathered through various means including face-to-face contact, tele-psychiatry or from external resources. Areas reviewed to meet the standard include surveyors reviewing the qualifications and training of those personnel providing consumers' assessments; ascertaining if pertinent information is obtained from the consumer, family and other collaterals; ascertaining if sufficient information is obtained to determine the consumers current and historical life situation in order to provide appropriate and safe services; determining if assessments are conducted within established time frames and result in a summary that is used in

developing an individual plan.

- The intent statement for the individual plan standard also emphasizes the consumer's active involvement with a significant role in the consumer's individual plan. The planning is consumer directed and person centered. CARF surveyors will assess the individual plan for consumer participation based on the involvement of consumer and family that are noted in the assessment and interpretive summary. Surveyors will look for identification of needs beyond program's scope, for specification of needs and services provided and/or referred, for communication with the consumer and family members and for periodic review and update of the individual plan. CARF surveyors will also look at the individual plan components for the following:
  - Are goals in the words of the consumer and family served?
  - Does it reflect the consumer and family had informed choice?
  - Is it appropriate for the consumer's culture and age?
  - Do the treatment objectives reflect consumer's and treatment team's expectations?
  - Are treatment objectives understandable, measurable, achievable and time-specific?
  - Does the plan reflect transition to other services?
  - Does it identify legal requirements or fees?

  Other items to be assessed in an individual plan as part of accreditation include:
  - If present, how are co-occurring disabilities/disorders addressed?
  - Is medical fragility considered in plan development?
  - Has the plan been reviewed and modified?
  - Are progress notes signed and dated?
  - Is there a designated service coordinator? Did the service coordinator ensure consumer orientation, plan implementation, identify gaps, share information on community resources, coordinate services and communicate after-hours process.

Distribution of Statewide Child Matched Reports for SFY 2005-2006

- Craddock, NDRI, shared the statewide version of the LME reports that have been distributed online to each LME Superuser account. She briefly discussed the time frame of these reports and noted that they may be useful when doing the CARF workgroup activity after lunch.

CARF Workgroup Activity

- After lunch, Migas introduced the workgroup outcomes management system exercise. She provided a handout that step through the process. She walked through examples of measures of effectiveness, efficiency and consumer satisfaction. She focused on access to the organization. Access could include call "holding", setting of first appointment, time between first and second appointment and follow-up. Examples of performance indicators for process concerns include – access to service waiting time, transportation and location of services, program responsiveness to consumer needs, client-driven services and information and personal dignity. Examples of performance indicators for outcome concerns include – financial status, health status, quality of life, psychological well-being, substance abuse/use reduction, personal safety, self-efficacy, living arrangements, educational status and improvements, employment

status and improvements and quality of relationships. Examples of performance indicators for consumer satisfaction included: were consumers given hope; were their expectations met; were they treated with empathy, respect and understanding; and how were complaints or grievances addressed.

- Before participants broke into four groups to design an outcomes management system, Migas framed and provided an example of the steps in an outcomes management system.
  - Develop a program objective
  - Develop performance indicator which is how the objective is measured
  - Define the instruments, measures, or tools to be used to measure
  - Define sample or population and how a high response rate will be ensured
  - Define the time points at which data will be collected
  - Specify how data will be collected and by whom
  - Specify reporting process and audience(s)
  - Clarify how information results will be used
- The four groups reported their outcome management system design.
- Migas concluded her presentation highlighting that the NC-TOPPS process and data aid in gathering outcomes and help provide focus for the outcomes management system.

Division Perspective on Accreditation & Accountability

- Jim Jarrard, Division's Accountability Team Leader, shared information on the proposed Division rule and November 14, 2005 memorandum on approved list of agencies that (a) may accredit providers of mhddsas services and (b) may accredit LMEs for systems management. He provided handouts on the rule and the memorandum. (Contact Cawley@ndri-nc.org for these handouts.)
- Jarrard noted that the DHHS shall approve each entity that may accredit a provider of mhddsas and the Department will maintain a list of approved accrediting bodies. These accrediting bodies must provide documentation to the Department showing that each has a minimum of two years of experience conducting accreditation reviews of providers of mhddsas services and that each has this experience in a minimum of three states other than North Carolina. Moreover, each accrediting body shall make available to the Department the accreditation procedures and standards it plans to employ.
- Each accrediting body must use standards that address areas of operations or their equivalent as follows: ethics; financial accountability; governance; human resources; quality management; and risk management. In addition, each accrediting body must use accreditation standards that address the clinical and programmatic requirements of each service that the provider plans to provide.
- The rule also provides a specific accreditation requirement for LMEs that also provide services. A provider that is also an LME must use a different accrediting body for the service(s) it plans to provide than it uses for accreditation of the systems management functions required on an LME.
- The four agencies approved by the Department to accredit providers of services are the:
  - Council on Quality and Leadership (CQL)

  - Council on Accreditation (COA)
  - Council on Accreditation of Rehabilitation Facilities, International (CARF)
  - Joint Commission for the Accreditation of Healthcare Organizations (JCAHO).
- The four agencies approved to accredit LMEs are:
  - National Committee for Quality Assurance (NCQA)
  - Utilization Review Accreditation Commission (URAC)
  - Council on Accreditation (COA)
  - Council on Accreditation of Rehabilitation Facilities, International (CARF).

Increasing Implementation Roundtable Follow-up

- McNeely, NCSU CUACS, distributed a handout (please see table below) that summarizes the roundtable discussion on "Increasing Implementation" from our October 26, 2006 meeting. Cawley reminded the group that at our last meeting it was requested that we review and update our discussion at upcoming meetings.
- McNeely addressed the actions being taken to address the barriers or suggestions offered at the last meeting.
  - She shared information about a federal State Outcomes Measurement and Management System (SOMMS) technical assistance (TA) RFP that is currently out for bid. Products of this TA grant will be the development of online queries and dashboards. These advanced queries will help provide the availability of data and reports to clinical staff, providers and LME staff. McNeely proposed that at our April meeting the Committee brainstorm on what queries would be useful.
  - As suggested, an Integrated Payment Reporting System (IPRS) Target Populations Definitions link was created on the NC-TOPPS website for clinician reference.
  - She noted that the December 15, 2006 training included a section on using NC-TOPPS in developing and updating a consumer's Person Centered Plan. The PowerPoint for this specific training is available at the NC-TOPPS website under Training Support.
- Cawley shared some additional input she received on increasing clinician use. A group of clinicians suggested that developing an NC-TOPPS narrative report on key areas of a consumer's diagnosis and behavior would enhance its usefulness to clinicians.
- Cawley advised that we will review the table again at our April meeting. The following table captures the information on McNeely's handout.

Increasing Compliance for NC-TOPPS Roundtable Discussion/Brainstorming

Barriers to Compliance	Suggestions/Ideas/Solutions	Actions
Immediate Data Available to Clinical staff		Advanced Queries to be developed by October 2007
	Pair NC-TOPPS with PCP	Presentation Available on-line that ties the NC-TOPPS with the development and updating of PCP
	Making NC-TOPPS a part of what is required/done by clinical staff and providers (monitoring, auditing, assessment)	
Discharge Compliance-engagement of consumer who has left services		
Providers don't feel they get the feedback from NC-TOPPS		Dashboard reports; Advanced Queries; Reports directly in Super-user accounts
Communicating to providers, LME		
Not being able to use the data to replace current system		
"Reports" available to clinical staff and super-users		Dashboard reports; Advanced Queries; Reports directly in Super-user accounts
	Advertise Gail's reporting capabilities	
Handling drop out discharge data-could we make this a shorter version?	Discuss this option with Management Team	
	Add IPRS Target Populations Definitions as a link	Done
Connecting Value Options and EDS info for the LME's		
Provider tracking by LME timely		
Put pertinent info in super-user 'accounts'		
	Copy LME Superuser's when responding to Provider clinicians	

Center for Substance Abuse Treatment Review

- Cawley briefed the Committee on the federal CSAT review of the Division. The CSAT technical review is an assessment of statewide systems that examines strengths, identifies major operational issues, and measures progress toward meeting SAPTBG objectives. There are two types of review, State-Requested and Revised Core Elements Review. The recent review is conducted every three years. The issues reviewed are: description of the State alcohol and drug system; state monitoring systems; compliance review; impact of technical assistance; and state issues including recurring issues from previous technical reviews. The technical review lasted one week. The first two days were spent interviewing staff in three primary areas: data management collection documentation; financial management documentation and quality management-clinical documentation. Eller, CUACS staff, gave a demonstration of the NC-TOPPS online system. Division staff provided and discussed NC-TOPPS reports and the collection of National Outcome Measures System (NOMS) and Treatment Episode Data System (TEDS) data. The next two days were spent at programs funded with SAPTBG monies. The review team visited McLeod Center-Opioid Treatment and Community Choices-Women's Program. The final day was an exit conference with State officials to discuss preliminary findings.
- The final report will include findings, but are not audit findings but rather show the State's needs for technical assistance. Preliminary findings indicate a positive impression of the State's data systems. Report suggestions may include more technical assistance to providers on integrating NC-TOPPS into PCP, provide more education to the field about National Outcome Measures and provide LME access to Medicaid claims data.

Update on Finance and Reimbursement Officers Association (FARO) and Community Support/Targeted Case Management (CS/TCM) Presentations

- McNeely shared that positive feedback was received on both of these presentations.
- She acknowledged Andy Smitley and Dave Peterson for their presentations at the FARO conference. They were so positively received she attempted to include them in the December 15, 2006 training. Smitley was unable to attend, but his presentation was provided as time allowed. Peterson did participate at both training sessions.
- The CS/TCM Conference presentation focused on NC-TOPPS and Person Centered Thinking and Planning Process. This presentation laid the groundwork for a section of the December 15 training. McNeely is communicating with Division staff that are developing PCP training to insure the integration of NC-TOPPS in the PCP training.

Training Update

- McNeely noted that two NC-TOPPS basic training sessions were provided on December 15 that included about 125 participants. As noted above, the training included the relationship between NC-TOPPS and PCP, Smitley's and Peterson's FARO presentations and walking through the online system.
- McNeely shared the work she and her staff are doing on developing an integrated training package that can be used by others (LMEs and providers) in conducting training sessions.
- Cawley asked for input on the need for CUACS to provide more basic training

sessions since it is the LME's responsibility to train providers on NC-TOPPS. Most members felt that the LMEs should be responsible for providing basic NC-TOPPS training to providers. Because of turnover in providers, LMEs need to provide training often, possibly monthly. If CUACS and NDRI receive calls on training, they should provide the caller with the LME contact. It was expressed that NC-TOPPS staff needs to move forward on providing training on how to use the data. Other members, however, commented that LMEs may need to have train the trainer training for various reasons, particularly due to LME staff turnover. It was suggested that CUACS could provide train the trainer sessions every 6 months. It was also suggested that matching inexperienced LME staff with experienced NC-TOPPS LME personnel be considered. It was also pointed out that someone new to NC-TOPPS can receive information by directly contacting CUACS personnel, by reviewing the Training Support materials found at the website and by working through the online system by using the "training" login and "training" password.

Other

- Cawley distributed two documents that Spencer Clark had emailed to her. These documents discuss performance and outcome measurement. For copies of these handouts, please contact Cawley@ndri-nc.org.
  - While distributing the "North Carolina Evidence Based Practices Center e-Newsletter, Byron Brooks from the Center, described the Center's mission and current activities. Cawley pointed out that the website address for accessing the e-Newsletter is on the bottom of the first page of the handout. Additionally, Brooks verbally provided the website address for the Center, which is http://www.ncebpcenter.org.
  - The second handout is Chapter 6, "Performance Improvement and Outcomes Monitoring" of a SAMHSA/CSAT Treatment Improvement Protocol No. 46. Substance Abuse: Administrative Issues in Outpatient Treatment. Cawley highlighted that many of the measures discussed are ones captured in the NC-TOPPS.
- Members expressed concern over the clarification at the December 15 training on NC-TOPPS requirement for children receiving medication management and/or outpatient therapy. It was expressed that it was too confusing to have to consider NC-TOPPS requirements based on both age and funding. Even more importantly, it appears to be a Guidelines change in mid-year when we had discussed not making such changes but once a year. McNeely explained how the clarification arose and why it is was presented at the training. She also noted that the Guidelines have not been updated. McNeely stated that the issue is on our upcoming NC-TOPPS management team agenda. We will discuss the concerns raised at the training and this meeting.
- Cawley led the group in thanking Janice Stroud for her long time membership on the Committee and participation in NC-TOPPS development.

Wrap Up and Adjournment

- The meeting was adjourned at 2:50 p.m. The next meeting is scheduled for April 26, 2007 from 10 a.m. to 3 p.m. at the NCSU University Club.